



## ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

### CHANGE OF OWNERSHIP EXEMPTION APPLICATION FOR AN EXISTING HEALTH CARE FACILITY AUGUST 2013 EDITION

#### ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD INSTRUCTIONS FOR THE COMPLETION OF APPLICATION FOR EXEMPTION CHANGE OF OWNERSHIP FOR AN EXISTING HEALTH CARE FACILITY

The attached form must be used for all transactions proposing a change of ownership of a health care facility. The requirements for issuance of an exemption are contained in 77 IAC 1130.520. Applicants should refer to IAC 1130.140 for definitions of a change of ownership and control of a health care facility. Applicants should also refer to 77 IAC 1130.220(a) for information on who the applicant(s) should be. Note the following requirements and guidelines pertaining to the Application for Exemption:

1. IAC 1130.520(a) prohibits any person from acquiring or entering into an agreement to acquire an existing health care facility prior to receiving approval from the State Board.
2. Complete the application with all applicable attachments. All pages and documents must be on single-sided paper size 8 1/2" x 11". Applicants should note that the required attachments to the application must be labeled and identified by attachment number. **FAILURE TO DO SO WILL RESULT IN THE APPLICATION BEING DEEMED INCOMPLETE.**
3. It is noted that all applications for exemption for the change of ownership of a health care facility are subject to the opportunity for a public hearing and public hearing requirements (77 IAC 1130.520(c) and (d)).
4. Applicants must submit a complete original application with original signature(s) and required appendices and attachments, as well as the APPLICATION FEE of \$2,500 payable by check or money order to the Illinois Department of Public Health. Submit the material to:

Courtney Avery, Administrator  
Illinois Health Facilities and Services Review Planning Board  
525 West Jefferson Street, Second Floor  
Springfield, Illinois 62761-0001

5. Per IAC 1130.550(b), the State Agency is allowed 30 DAYS (from the date of receipt of the application) to determine the application's completeness. **PLEASE REFRAIN FROM TELEPHONING THE STATE AGENCY FOR A STATUS REPORT ON YOUR APPLICATION. STAFF TIME ANSWERING PHONE INQUIRIES TAKES FROM STAFF TIME TO REVIEW APPLICATIONS.** The State Agency will contact you if your application is incomplete.

**NOTE: "The Illinois Health Facilities and Services Review Board does not discriminate on the basis of handicap in admission or access to, or treatment or employment in its programs and activities in compliance with Section 504 of the Rehabilitation Act of 1973, as amended. The Equal Employment Opportunity Officer is responsible for coordination of compliance efforts; voice (217) 785-2034; TDD (217) 785-2088."**

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
APPLICATION FOR EXEMPTION FOR THE  
CHANGE OF OWNERSHIP FOR AN EXISTING HEALTH CARE FACILITY**

**1. INFORMATION FOR EXISTING FACILITY**

Current Facility Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_  
Name of current licensed entity for the facility \_\_\_\_\_  
Does the current licensee: own this facility \_\_\_\_\_ OR lease this facility \_\_\_\_\_ (if leased, check if sublease ☐)  
Type of ownership of the current licensed entity (check one of the following:) \_\_\_\_\_ Sole Proprietorship  
\_\_\_\_\_ Not-for-Profit Corporation \_\_\_\_\_ For Profit Corporation \_\_\_\_\_ Partnership \_\_\_\_\_ Governmental  
\_\_\_\_\_ Limited Liability Company \_\_\_\_\_ Other, specify \_\_\_\_\_  
Illinois State Senator for the district where the facility is located: Sen. \_\_\_\_\_  
State Senate District Number \_\_\_\_\_ Mailing address of the State Senator \_\_\_\_\_  
\_\_\_\_\_  
Illinois State Representative for the district where the facility is located: Rep. \_\_\_\_\_  
State Representative District Number \_\_\_\_\_ Mailing address of the State Representative \_\_\_\_\_  
\_\_\_\_\_

- 2. OUTSTANDING PERMITS.** Does the facility have any projects for which the State Board issued a permit that will not be completed (refer to 1130.140 "Completion or Project Completion" for a definition of project completion) by the time of the proposed ownership change? Yes ☐ No ☐. If yes, refer to Section 1130.520(f), and indicate the projects by Project # \_\_\_\_\_

- 3. NAME OF APPLICANT** (complete this information for each co-applicant and insert after this page).

Exact Legal Name of Applicant \_\_\_\_\_  
Address \_\_\_\_\_  
City, State & Zip Code \_\_\_\_\_  
Type of ownership of the current licensed entity (check one of the following:) \_\_\_\_\_ Sole Proprietorship  
\_\_\_\_\_ Not-for-Profit Corporation \_\_\_\_\_ For Profit Corporation \_\_\_\_\_ Partnership \_\_\_\_\_ Governmental  
\_\_\_\_\_ Limited Liability Company \_\_\_\_\_ Other, specify \_\_\_\_\_

- 4. NAME OF LEGAL ENTITY THAT WILL BE THE LICENSEE/OPERATING ENTITY OF THE FACILITY NAMED IN THE APPLICATION AS A RESULT OF THIS TRANSACTION.**

Exact Legal Name of Entity to be Licensed \_\_\_\_\_  
Address \_\_\_\_\_  
City, State & Zip Code \_\_\_\_\_  
Type of ownership of the current licensed entity (check one of the following:) \_\_\_\_\_ Sole Proprietorship  
\_\_\_\_\_ Not-for-Profit Corporation \_\_\_\_\_ For Profit Corporation \_\_\_\_\_ Partnership \_\_\_\_\_ Governmental  
\_\_\_\_\_ Limited Liability Company \_\_\_\_\_ Other, specify \_\_\_\_\_

- 5. BUILDING/SITE OWNERSHIP. NAME OF LEGAL ENTITY THAT WILL OWN THE "BRICKS AND MORTAR" (BUILDING) OF THE FACILITY NAMED IN THIS APPLICATION IF DIFFERENT FROM THE OPERATING/LICENSED ENTITY**

Exact Legal Name of Entity That Will Own the Site \_\_\_\_\_  
Address \_\_\_\_\_  
City, State & Zip Code \_\_\_\_\_  
Type of ownership of the current licensed entity (check one of the following:) \_\_\_\_\_ Sole Proprietorship  
\_\_\_\_\_ Not-for-Profit Corporation \_\_\_\_\_ For Profit Corporation \_\_\_\_\_ Partnership \_\_\_\_\_ Governmental  
\_\_\_\_\_ Limited Liability Company \_\_\_\_\_ Other, specify \_\_\_\_\_

- 6. TRANSACTION TYPE. CHECK THE FOLLOWING THAT APPLY TO THE TRANSACTION:**
- Purchase resulting in the issuance of a license to an entity different from current licensee;
  - Lease resulting in the issuance of a license to an entity different from current licensee;
  - Stock transfer resulting in the issuance of a license to a different entity from current licensee;
  - Stock transfer resulting in no change from current licensee;
  - Assignment or transfer of assets resulting in the issuance of a license to an entity different from the current licensee;
  - Assignment or transfer of assets not resulting in the issuance of a license to an entity different from the current licensee;
  - Change in membership or sponsorship of a not-for-profit corporation that is the licensed entity;
  - Change of 50% or more of the voting members of a not-for-profit corporation's board of directors that controls a health care facility's operations, license, certification or physical plant and assets;
  - Change in the sponsorship or control of the person who is licensed, certified or owns the physical plant and assets of a governmental health care facility;
  - Sale or transfer of the physical plant and related assets of a health care facility not resulting in a change of current licensee;
  - Any other transaction that results in a person obtaining control of a health care facility's operation or physical plant and assets, and explain in "Attachment 3 Narrative Description"
- 7. APPLICATION FEE.** Submit the application fee in the form of a check or money order for \$2,500 payable to the Illinois Department of Public Health and append as **ATTACHMENT #1**.
- 8. FUNDING.** Indicate the type and source of funds which will be used to acquire the facility (e.g., mortgage through Health Facilities Authority; cash gift from parent company, etc.) and append as **ATTACHMENT #2**.
- 9. ANTICIPATED ACQUISITION PRICE:** \$ \_\_\_\_\_
- 10. FAIR MARKET VALUE OF THE FACILITY:** \$ \_\_\_\_\_  
(to determine fair market value, refer to 77 IAC 1130.140)
- 11. DATE OF PROPOSED TRANSACTION:** \_\_\_\_\_
- 12. NARRATIVE DESCRIPTION.** Provide a narrative description explaining the transaction, and append it to the application as **ATTACHMENT #3**.
- 13. BACKGROUND OF APPLICANT** (co-applicants must also provide this information). Corporations and Limited Liability Companies must provide a current Certificate of Good Standing from the Illinois Secretary of State. Limited Liability Companies and Partnerships must provide the name and address of each partner/ member and specify the percentage of ownership of each. Append this information to the application as **ATTACHMENT #4**.
- 14. TRANSACTION DOCUMENTS.** Provide a copy of the complete transaction document(s) including schedules and exhibits which detail the terms and conditions of the proposed transaction (purchase, lease, stock transfer, etc). Applicants should note that the document(s) submitted should reflect the applicant's (and co-applicant's, if applicable) involvement in the transaction. The document must be signed by both parties and contain language stating that the transaction is contingent upon approval of the Illinois Health Facilities and Services Review Board. Append this document(s) to the application as **ATTACHMENT #5**.
- 15. FINANCIAL STATEMENTS.** (Co-applicants must also provide this information) Provide a copy of the applicants latest audited financial statements, and append it to this application as **ATTACHMENT #6**. If the applicant is a newly formed entity and financial statements are not available, please indicate by checking YES \_\_\_\_ , and indicate the date the entity was formed \_\_\_\_\_

**16. PRIMARY CONTACT PERSON.** Individual representing the applicant to whom all correspondence and inquiries pertaining to this application are to be directed. (Note: other persons representing the applicant not named below will need written authorization from the applicant stating that such persons are also authorized to represent the applicant in relationship to this application).

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State & Zip Code: \_\_\_\_\_  
Telephone ( ) Ext. \_\_\_\_\_

**17. ADDITIONAL CONTACT PERSON. Consultant, attorney, other individual who is also authorized to discuss this application and act on behalf of the applicant.**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State & Zip Code: \_\_\_\_\_  
Telephone ( ) Ext. \_\_\_\_\_

**18. CERTIFICATION**

I certify that the above information and all attached information are true and correct to the best of my knowledge and belief. I certify that the number of beds within the facility will not change as part of this transaction. I certify that no adverse action has been taken against the applicant(s) by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois. I certify that I am fully aware that a change in ownership will void any permits for projects that have not been completed unless such projects will be completed or altered pursuant to the requirements in 77 IAC 1130.520(f) prior to the effective date of the proposed ownership change. I also certify that the applicant has not already acquired the facility named in this application or entered into an agreement to acquire the facility named in the application unless the contract contains a clause that the transaction is contingent upon approval by the State Board.

Signature of Authorized Officer \_\_\_\_\_

Typed or Printed Name of Authorized Officer \_\_\_\_\_

Title of Authorized Officer: \_\_\_\_\_

Address: \_\_\_\_\_

City, State & Zip Code: \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE: complete a separate signature page for each co-applicant and insert following this page.**